The principal teaching hospital for Tufts University School of Medicine

Tufts Medical Center

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Exhibit B: Instructions and Questions for Written Testimony
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1. **After reviewing the preliminary reports located at *www.mass.gov/dhcfp/costtrends,* please provide commentary on any finding that differs from your organization's experience. Please explain the potential reasons for any differences.**

Tufts Medical Center (Tufts MC) and New England Quality Care Alliance (NEQCA) agree with the overall findings that significant price variations exist among providers in the healthcare market and that these price variations have no correlation to the quality of care provided or to the acuity level of a provider's the patient population. We also agree with the finding that providers with high Medicaid volume do not hold the leverage over private payers to garner high prices. In fact, Tufts MC has a Medicaid volume of 25%, and it has been our experience that a high public payer mix makes a provider more acutely vulnerable to changes in commercial insurance rates and payment policy and reductions in government reimbursements.

2. **How much have your costs increased from 2005 to 2010? (Percents by year are fine.)**
    a. **Please list the top five reasons for these increases, with the most important reason first.**

FY2006	FY2007	FY2008	FY2009	FY2010
6.8%	2.0%	6.7%	4.10%	5.14%

- Increases in volume were major drivers of increased expenses over this time period. From FY2006 through FY2010 our inpatient discharges grew by 22%, while our overall expenses increased by 4.9%.
- Increases in labor costs, salaries, wages and benefits were significant cost increases.
- Bad debt and uncompensated care also drove expenses.
- Medical Inflation and cost of technology also drove increases in expenses from FY2005-FY2010.

3. **What specific actions has your organization taken to contain health care costs? Please also describe what, if any, impact these strategies have had on health care costs, service quality, and patient outcomes. What current factors limit the ability of your organization to execute these strategies effectively?**

Tufts Medical Center and New England Quality Care Alliance are proud of their position in the market as a high-quality, efficient providers. NEQCA is a group of 1,500 physicians

under the same corporate umbrella as Tufts Medical Center. Since the inception of NEQCA in 2005, Tufts MC and NEQCA's joint strategy has been to provide patients with the right care in the right place at the right time. Tufts MC is among the lowest-paid AMCs in Massachusetts, and many NEQCA physicians are lower paid than others in their market. Yet most third-party quality measures show our quality to be among the best in the country. In 2010, Tufts Medical Center ranked 6th in the University Health System Consortium's quality rankings of 98 percent of the AMCs in the nation. This ranking looks at a broad range of objective and nationally-accepted quality measures. None of our local competitors ranked in the top ten on this list, despite the fact that Tufts MC is paid less than almost all of them, and paid less than even some local community hospitals.

In the past several years, we have formed strong clinical affiliations with community hospitals throughout Eastern Massachusetts. These affiliations have not involved mergers or acquisitions; rather, they have occurred as a result of a desire by our community partners, Tufts MC and NEQCA to work closely together to deliver high-quality and efficient care for our patients. Like Tufts MC, many of our community partners are paid less than their peers but they exhibit high quality. Many of these hospitals are the primary referring hospitals for our NEQCA physicians.

In our model, called the Distributed Academic Medical Center™ model, Tufts MC physicians provide services in the community, enabling these lower-cost community hospitals to expand their services and keep more care from going to tertiary providers when not necessary. This creates significant savings in the market. We encourage our community partners to refer their truly tertiary cases to Tufts MC, but we aspire to earn this business, not dictate that it come to us. When patients in need of tertiary care are referred to us, it almost always costs the system less than if the cases were referred to any other local AMC. This is in direct contrast to the traditional hub-and-spoke model in which AMCs build "feeders" in the community to send more care downtown.

In addition to focusing on ensuring that care is provided in the most cost effective high quality location, NEQCA has focused on several other areas:

- Care delivery redesign including implementation of the patient centered medical home model.
- Improved management of pharmacy costs.
- Readmission prevention
- Implementation of disease management programs including: Congestive heart failure, chronic obstructive pulmonary disease, care transitions program, high risk care management program.
- Implementation of a diabetes care improvement program.
- Enhanced quality reporting and chronic disease registry use throughout the network.
- Development of network wide structures and processes to improve quality and identify and manage efficiency opportunities.
- Physician leadership development
- Provision of enhanced quality and efficiency reporting across the network.

4. **What types of systemic changes would be most helpful in reducing costs without sacrificing quality and consumer access? What systemic actions do you think are necessary to mitigate health insurance premium growth in Massachusetts? What other systemic or policy changes do you think would encourage or help health care providers to operate more efficiently?**

Tufts Medical Center and New England Quality Care Alliance believe many system changes can and should be pursued to help stem the rising healthcare cost trend.

- **Close the payment gap:** The current healthcare market of staggering rate differential is unsustainable and the market of high cost "haves" and low cost "have-nots" that has been perpetuated only serves to marginalize high quality, efficient providers, leaving a market dominated by high cost providers; therefore continuing to drive an increase in costs. It is reasonable for insurers to have to prove that they are not discriminating against hospitals and physicians with more than a 15% Medicaid mix and are paying them a market-competitive rate, which should be at least at the average of other hospitals in their markets and peer groups. Once the payment gap is addressed, global payment contracts could be effective in aligning incentives to achieve high quality and efficient health care.
- **Peer group analysis:** It is critical to have accurate evaluations and analysis of cost differentials and efficiency across different types of providers. As price variations are addressed, providers must be grouped and analyzed by appropriate peer group, e.g. AMCs, Community Hospitals.
- **Uniform and transparent payment rules:** A uniform base payment format, such as a single base fee schedule, claims submission format, and payment policies and procedures across <u>all</u> payers will help drive balance and transparency in the market. Instituting a uniform base payment format will help create true "apples to apples" comparisons, will allow providers and payers to negotiate inflators and deflators on a standard fee schedule, will remove incentives for perverse contracting practices and arbitrary supplemental payments, and will create substantial savings through administrative efficiencies.
- **Constraints on unilateral heath plan policy revisions:** Unconstrained health plan practices of making unilateral policy changes outside of normal contract negotiations continue to erode the stability of low cost providers and are detrimental to the patient experience. Health plans should be required to work with providers in addressing policy changes in a manner that does not undermine the financial stability of an institution or negatively impact patient care.
- **Adequate government reimbursement:** As the DCHFP report verifies, providers with a high public payer mix do not receive high private reimbursement rates. Adequate government payment rates are not only critical to sustaining high-quality, lower-cost providers in the market, but they play a direct role in reducing premium costs. If public payers paid at cost for services received, the premium to private employers could be reduced by approximately 16%.
- **Health plan reserve transference commensurate with risk transference:** As more of the market moves to risk-based payment models and physicians assume risk

for their patient populations, health plans should transfer the portion of the premium they collect and hold as risk reserves to the physicians. This will help ensure physicians and providers can meet the capital requirements necessary to assume the risk with patients and build the necessary infrastructure to bolster care coordination and reduce the potential of adverse events.

- **Care management resources:** Health plan care management s resources should be shifted to appropriate provider organizations to implement care delivery redesign and to provide integrated care management at the practice level.
- **Triple Aim incentive alignment:** Align all hospitals and physician incentives with achieving the Triple Aim of better care for individuals, better population health and reducing the rate of increase in per capita health care costs consistent with the incentives in NEQCA's risk contracts.
- **Access to comprehensive data:** Access to accurate and timely and comprehensive quality and efficiency data on all patients will assist in better manage care.
- **Benefit design changes:** Offer value based benefit design to encourage patient engagement.

5. **What do you think accounts for price variation across Massachusetts providers for similar health care services? What factors, if any, should be recognized in differentiated prices?**

It is well known that quality at Massachusetts hospitals is outstanding compared to the rest of the country. There are differences in quality among institutions, but the Attorney General has shown that those differences bear no relation to how much providers are paid. The Attorney General's 2010 report clearly showed that the factors that most strongly influenced prices paid by insurers were brand-name recognition and market clout as well as geographic isolation. It has also been demonstrated that providers who treat more patients covered by government programs do not receive higher payments from commercial insurers to make up for the underpayment by the government. In fact, it has been shown that the more Medicaid patients a hospital treats, the lower its commercial reimbursements tend to be. We agree with those assessments.

Several factors that *should* be recognized in differentiated prices are:

- Safety net and Medicaid mix
- Acuity – the severity of illness treated by the provider
- Teaching status – Academic Medical Centers bear a significant burden in training the next generation of physicians and other caregivers, and they also are required to maintain and provide a higher level of critical services essential to all communities.
- Quality – providers should be reimbursed for keeping patients healthy
- Efficient care management – providers who demonstrate efficiency in treating patients should not be penalized by well-below market rates.

6. What policy or industry changes would you suggest to encourage treatment of routine care at less expensive, but clinically appropriate settings? (Routine care is defined here as non-specialty care that could be provided at a community hospital or in a community setting).

We believe our Distributed Academic Medical Center™ Model, described in Question 3, is one terrific antidote to a system that encourages care to be sent to the most expensive setting rather than the most appropriate setting.

We also believe that insurance products such as tiered or limited networks, which encourage consumers to use lower-cost providers, are critical to directing care where it belongs.

Support for community primary care would be helpful in encouraging the treatment of routine care in cost effective settings. Primary care providers need relief from the ever growing burden of providing care to more and more complex and chronically ill patients with fewer physicians entering into primary care practices. The system should support integrated care delivery models such as the patient centered medical home by providing incentives and reimbursement for the extra value delivered and services provided in this model.

7. Which quality measures do you most rely on to measure and improve your own quality of care?

Tufts Medical Center provides a broad scope of patient care services. Our quality program is data driven and focuses on high risk and problem prone processes and programs. Priority quality initiatives and measures are approved and supported by the hospital's governance, senior leadership, and Medical Staff on an annual basis. Leadership and staff participate in the performance improvement activities related to these key priority initiatives.

Key quality measures include:

- Catheter related central line infections
- Catheter related urinary tract infections
- Surgical site infections
- Patient falls
- Pressure ulcers
- Ventilator related pneumonia
- Acute Myocardial Infarction care
- Pneumonia care
- Congestive Heart Failure care
- Surgical Care Improvement Project
- Readmissions
- Adverse drug events
- Post operative complications
- Compliance to the Joint Commission's National Patient Safety Goals

- Hand Hygiene
- Inpatient mortality (mortality index)
- Serious Reportable Events (SRE's) and Never Events
- Patient experience (Press Ganey and HCAHPS)
- Stroke care

NEQCA key quality measures include:

2011 All Payor Quality Measures

1. Diabetes HbA1c Testing
2. Diabetes Eye Exams
3. Diabetes Nephropathy Screening
4. Diabetes LDL-C Screening
5. Cardiovascular LDL-C Screening
6. Breast Cancer Screening
7. Cervical Cancer Screening
8. Colorectal Cancer Screening
9. Chlamydia Screening Ages 16-20
10. Chlamydia Screening Ages 21-24
11. Well Child Visits < 15 months
12. Well Child Visits Ages 3-6
13. Well Child Visits Adolescent
14. BMI (Pediatric only)
15. Anti Depressant Medication Acute Phase
16. Anti Depressant Medication Continuation Phase
17. Avoidance Antibiotics in Acute Bronchitis (Adult)
18. Appropriate Treatment URI (Pediatric)
19. Appropriate Treatment Pharyngitis (Pediatric)
20. Asthma Medication Management
21. Annual Monitoring Patients on Persistent Medication (Digoxin)
22. Rheumatoid Arthritis Management
23. Use of Spirometry Testing n Assessment and Diagnosis of COPD
24. Osteoporosis Management Post-FX
25. Glaucoma Testing
26. Diabetes HbA1c Control (outcome)
27. Diabetes LDL Control
28. Diabetes Blood Pressure Control
29. Hypertension Control (outcome)
30. Cardiovascular LDL-C Control (<100mg)

Patient Experience

1. Improve Patient Experience Access to Care Adult and Pediatric
2. Improve Patient Experience Integration of Care Adult and Pediatric
3. Improve Patient Experience of Knowledge of the Patient Adult and Pediatric

4. Improve Patient Experience of Physician Communication Adult and Pediatric

8. We found that there is substantial price variation occurring for several types of health care services (although for some more than others), but that the wide variation in prices for hospital care does not appear to represent any corresponding gain in quality based on the existing quality measures that we were able to use in this analysis. Does your organization believe that price is correlated with quality? What role do you think quality should play in determining prices, and does the health care community currently collect the right types of quality measures?

While a number of insurance products incentivize providers to reach quality goals with additional payments for achieving benchmarks, these incentive payments tend not to change the underlying rates paid to providers, and hence they have yet to do anything to change the inequities among providers in this market. We do think that providers should be rewarded for high quality and incentivized to provide high-quality care, but underlying price differentials that are unrelated to quality must still be addressed.

To be most effective in correlating prices with quality, improvements in the measurement systems need to occur. Very importantly in ambulatory care is moving from quality metrics based on claims to metrics based on actual clinical information from electronic medical records.

9. We found that for many inpatient DRGs, a large portion of patient volume is clustered in the most expensive quartile(s) of providers. Please provide your organization's reaction to these findings.

We were disappointed but not surprised by these findings. There are currently few incentives for consumers to seek care at high-quality, low-cost providers and so many simply seek their care at the best-known, best-marketed providers.

10. What tools should be made available to consumers to make them more prudent purchasers of health care?

Consumers should have better access to data that reflects the cost and quality of the providers they choose. However, it is unlikely that consumers will respond to this information unless they are prompted to do so by insurance plan designs that encourage them to seek out low-cost, high-quality providers. Insurers must also provide real-time information about benefit design to providers, so that individuals and their caregivers can be fully-informed about the choices patients are being asked to make.

11. What are the advantages and disadvantages of complete price transparency (e.g., consumers being able to see what prices are paid by carriers to different providers

for different services) from your organization's perspective? What about complete quality transparency?

We believe that cost and quality transparency would be helpful to consumers, but it should not fall to providers alone to be transparent. The true administrative costs of health plans – including what it costs providers to cope with a myriad of different benefit designs – should also be available to consumers, particularly to employers who do the vast majority of health plan purchasing in the state.

12. **Before your organization decides to acquire new service lines, capacity, or major equipment, does it consider the current capacity of nearby providers? What do you feel the state's role should be in health care resource planning (beyond or including its current Determination of Need process)?**

Tufts Medical Center has always been extremely judicious in adding additional services or facilities. We have not built new buildings on our campus in many years. Currently, we look at our services with an eye toward the requirements of our affiliates and our NEQCA physicians as driven by patient needs. We look to respond to their needs in a fiscally responsible way.

13. **How ready does your organization feel it is to join, affiliate with, or become an Accountable Care Organization (ACO)? Please explain.**

We believe that Tufts MC, NEQCA and our affiliates through our Distributed Academic Medical Center™ model are building a prototypical ACO. It is our plan that we will increase the level of care coordination through information technology to share a common medical record. We are reducing duplication of services and encouraging patients to receive their care in the most appropriate setting. We feel those principles must be at the heart of any ACO.

   a. **Is your organization interested in joining a Medicare Shared Savings ACO, as recently outlined by the Centers for Medicare and Medicaid Services (CMS)?**
   Tufts MC and NEQCA are keenly interested in the Medicare Shared Savings ACO model, however we have expressed significant reservations around the current regulations as they pertain to operational flexibility, financial feasibility, and successful population management.

   b. **If your organization doesn't feel ready to join any type of ACO, what types of supports or resources would it need to be able to join one?**

14. **Does your organization have any direct experience with alternative payment methods (bundled payments, global payments, etc.)? What have been the effects in terms of health care cost, service quality, and patient outcomes?**

All of the physicians in NEQCA including the Tufts MC Physicians Organization, which encompasses the 500 physicians who work at Tufts Medical Center, participate in the Blue Cross and Blue Shield Alternative Quality Contract (AQC). Our physicians' quality scores

have improved under the AQC and we are proud to say we have met nearly all the benchmarks that were set by BCBS.

15. Please identify any additional cost drivers that you believe should be examined in subsequent years and explain your reasoning.

We believe that all participants in the health care market – insurers, consumers, providers, employers and the government – have a role to play in driving cost in this market.

Insurers continue to provide a dizzying array of plan designs that cost providers millions of dollars to administer each year. These costs have been largely ignored in the discussion of health care costs and they must be examined and addressed. We also believe the public would benefit from an analysis of the medical loss ratio claimed by health plans. Health plans are quick to point to the 90% of the premium dollar that is categorized as medical costs and providers often questions the content and value of health plan services included in that 90%.

While products that encourage consumers to choose lower-cost, high-quality providers are beginning to catch on, too many consumers have little or no skin in the game when it comes to their own health care. The state must continue to encourage insurance products that incentivize consumers to receive their care in the appropriate setting, and to adopt healthy habits that will eliminate the need for much care in the first place. Insurers must also provide real-time information about benefit design to providers, so that individuals and their caregivers can be fully-informed about the choices patients are being asked to make. Benefit design that decreases barriers to improving care such as waived copayments for follow up of chronic illness or certain critical medications should be tested in the future. Additionally, benefit designs that create incentives for participation in health improvement activities should also be considered.

We are encouraged that more employers are choosing insurance plans that incentivize their employees to choose high-quality, more efficient providers, but employers must do more to educate their employees about their own role in driving health care costs.

And finally, government must acknowledge its role in driving up private premiums. Although the providers who care for the most Medicaid patients tend to have the lowest commercial payments, these providers are nevertheless forced to try to seek higher reimbursements to compensate.

16. Please provide any additional comments or observations you believe will help to inform our hearing and our final recommendations.